Forum Session

NATIONAL HEALTH POLICY FORUM

Perspectives on the Health Care Safety Net: Providers and Patients in Jeopardy

Thursday, May 3, 2001
9:30 to 10:00 am - Refreshments
10:00 am to noon - Discussion
Noon to 1:00 pm - Lunch and Informal Discussion
Congressional Hall of Honor, Fifth Floor
Reserve Officers Association Building
One Constitution Avenue, N.E.
(Across from Dirksen Senate Office Building)

A discussion featuring

Raymond Baxter, Ph.D.
Executive Vice President
Lewin Group

Susan E. Nestor Levy
Senior Vice President for Advocacy and External Relations
Ascension Health
St. Louis, Missouri

John G. O'Brien
Chief Executive Officer
Cambridge Health Alliance
and
Commissioner of Health
Cambridge, Massachusetts

Mario F. Pacheco, M.D.
Robert Wood Johnson Foundation Fellow
Office of Sen. Jeff Bingaman

Registration: Please call **Dagny Wolf at 202/872-1392** as soon as possible.

The George Washington University
WASHINGTON DC

The Health Care Safety Net

It is widely understood that the safety net offers health care to those without the resources to pay for it—including the uninsured, the underinsured, and the indigent in general. Less well known is that the safety net plays an important role in providing health care to those who face other impediments to care—including cultural and linguistic obstacles, geographic barriers, hindrances related to distance and shortages of providers, and numerous other more insidious bars to access. Thus, in a very real sense, safety-net providers act as a bridge to medical attention for millions of Americans across a chasm that is caused not only by lack of money and insurance coverage, but also by many other factors. In addition, some safety-net providers offer services of importance to the general population, including emergency departments, shock-trauma care, burn centers, and poison control. (An accompanying Forum background paper, "The Health Care Safety Net in a Time of Fiscal Pressures," provides greater detail on safety-net providers, patients, and funding sources, as well as the public policy and the socioeconomic trends affecting the safety net's viability.)

In March 2000, the Institute of Medicine issued a report entitled *America's Health Care Safety Net: Intact but Endangered*, which underscored the special jeopardy facing community health centers, public hospitals, certain community hospitals, and a number of other safety-net providers. Confronted by 42.6 million uninsured Americans in 1999, a managed care phenomenon that limited their ability to shift costs to other third-party payers, and increased competition for insured patients, safety-net providers found themselves under serious financial pressure. Following the failure of the Clinton health plan, it seems unlikely that the nation will consider any proposals for universal coverage for the immediate future, although incremental expansions of coverage—such as that exemplified by the State Children's Health Insurance Program (SCHIP) enacted in 1997—are on the table. The reliance of the nation—and the millions of Americans with access problems—on the safety net is likely to continue for decades to come. Because of this, pressures on the safety net are unlikely to ease.

For a number of reasons, it is an appropriate time to examine issues related to the safety net. The Bush administration has committed to a major expansion—1,200 new centers over a five-year period—in the community and migrant health center program, the single most important federal grant-in-aid program for the safety net. Congress is also considering the reauthorization of health centers, the National Health Services Corps, and other safety-net programs. The National Governors' Association has called for a major restructuring of the Medicaid program, the major source of patient revenue for safety-net providers, to allow the states to cover more of the uninsured with a less rich benefit package. At the same time, the National Conference of State Legislatures reports that 23 states' and the District of Columbia's Medicaid programs are experiencing budgetary overruns.[1] While the number of uninsured Americans declined in 1999 for the first time since 1987, there are a number of signs that this reversal is only momentary and that the pressures exerted on the safety net by what some observers have called "our nation's uninsurance epidemic"[2] may increase again.

A number of federal programs offer vital support to safety-net providers. Yet there is strong evidence that safety nets are essentially local phenomena, organized—to the extent that they *are* organized—at the local level and to a great extent shaped by state and local political, social, and economic forces. The interaction of these federal and state influences has significant consequences for the patients who depend on the safety net.

THIS FORUM MEETING

This Forum meeting will focus on the patients and providers included under the rubric of the safety net.

FORUM SESSION

Analyst/Writer:
Richard E. Hegner

National Health Policy Forum
2131 K Street, NW, Suite 500
Washington, DC 20037
202/872-1390
202/862-9837 (fax)
nhpf@gwu.edu (e-mail)
www.nhpf.org (Web site)

Judith Miller Jones, Director
Karen Matherlee, Co-Director
Judith D. Moore, Co-Director
Michele Black, Publications Director

NHPF is a nonpartisan education and information exchange for federal health policymakers.

Two subsequent meetings will examine the financial underpinnings of the safety net and innovative approaches to orchestrating safety-net providers at the local level in order to maximize the output of services within existing financial resources.

Key Questions

Drawing on the experiences of a group of speakers experienced in the delivery of safety net services, this session will attempt to present the audience with a graphic understanding of the situation confronting both patients and providers. Among the questions to be considered are the following:

- Can the safety net be characterized as a mix of providers defined in large part by the categorical programs that provide care to specific populations (such as persons who lack insurance, those who are homeless, those with HIV/AIDS, residents of rural areas, Native Americans who qualify for Indian Health Service care, and people with mental illness or substance abuse problems)? To what degree do patients who use safety-net providers have some kind of insurance coverage from the private sector or through Medicare or Medicaid entitlements?
- How much of the burden of care provided by the safety net might be considered as meeting chronic rather than acute medical care needs? How often are chronic care patients able to get the coordinated services they require from referral specialists? What seem to be the barriers to referral services, financial and otherwise?
- What portion of the safety net burden is currently being carried by community and migrant health centers? By rural health clinics? By nursing centers? By local health departments? By community hospitals? By public hospitals? By individual practitioners? By other providers? What are the most frequent kinds of problems they see?
- What are the tensions that exist in some areas between health centers and referral facilities or providers? What factors in addition to differential rates of pay contribute to such difficulties? And what accounts for the good relationships that exist elsewhere?
- From a patient perspective, especially in terms of the continuum of care, how wide are the gaps in the health care safety net? By population group? For the low-income uninsured? For immigrants? For others, such as nonreservation Native Americans and illegal aliens?
- Even with a more fully comprehensive system of public and private coverage, would there still be a residual need for a safety net? If so, what types of patients would it serve?

Speakers

Raymond Baxter, Ph.D., executive vice president of the Lewin Group, will lead off by reviewing the recent IOM report and the history of safety-net policy in the United States. He will comment on his experience working for safety-net providers and review his research in this area. Baxter heads Lewin's national research, policy, and management practice. He served as a member of the IOM Committee on the Changing Market, Managed Care, and the Future Viability of Safety Net Providers. His research and consulting focus on community health, health systems reform, policy development, organizational change and strategic planning. He has worked with government and the private sector at the state, local, and national levels and has over 20 years of experience in public health management, including heading the San Francisco Department of Public Health and the New York City Health and Hospitals Corporation. Baxter recently completed an evaluation of the nation's disease surveillance capacity for the assistant secretary of the Department of Health and Human Services and has headed the 12-site community tracking initiative of the Center for Studying Health System Change, funded by the Robert Wood Johnson Foundation. He holds a Ph.D. degree from the Woodrow Wilson School of Public and International Affairs at Princeton University.

Mario F. Pacheco, M.D., a board certified family physician who has provided comprehensive family care to medically indigent populations, will discuss his experience as a safety-net clinician and comment on the role of community health centers as safety-net providers. He is currently a Robert Wood Johnson Health Policy Fellow in the Office of U.S. Sen. Jeff Bingaman (D-N. Mex.). Pacheco is the founding director of the Northern New Mexico Family Practice Residency Program, a rural residency training track sponsored by the University of New Mexico (UNM) School of Medicine, where he received his M.D. degree in 1986. He has worked as a staff physician for the community health center in Santa Fe for ten years and is a diplomate and a fellow of the American Academy of Family Physicians. After completion of his residency in family medicine at the UNM Department of Family and Community Medicine, he remained at UNM for a one-year fellowship in health of the public. His main

professional interest is exploring ways to improve health services access to rural and uninsured families in Northern New Mexico, where health statistics are consistently among the worst in the nation.

John G. O'Brien is the chief executive officer of the Cambridge Health Alliance, a Harvard-affiliated health system that includes the Cambridge and Somerville hospitals, 23 primary care sites, a Medicaid managed care plan and a physician-hospital organization. He also serves as the commissioner of health for the City of Cambridge, Massachusetts. Cambridge Health Alliance is one of the ten largest health systems and is proportionally the largest provider of care to the indigent in Massachusetts. O'Brien is the chairman of the board of the National Association of Public Hospitals, and is a past-chairman of the board of the Massachusetts Hospital Association. He will discuss the unique perspective of the Cambridge Health Alliance as a multi-faceted safety-net provider and talk about the safety-net role of public hospitals and local health departments. O'Brien began his career at the Cambridge Hospital in 1976, assuming his current post in 1986. O'Brien received his master's degree in business administration at Boston University.

Susan E. Nestor Levy, senior vice president for advocacy and external relations at Ascension Health, will discuss the growing importance of private safety-net providers. She is responsible for national advocacy, government relations efforts, and system-wide initiatives for the poor on behalf of Ascension Health. In addition, she is responsible for partnerships with key organizations essential to implementing Ascension Health's advocacy agenda. Before joining Ascension Health, Levy served as the executive director of policy in the Office of Policy and Representation for the Blue Cross and Blue Shield Association, where she was responsible for formulating the association's policy on health care legislation. From 1992 to 1996, she served as a health care policy expert to the U.S. Senate Committee on Finance, where she was a key staff member for Medicare payment legislation and involved in numerous other legislative activities during the Clinton health reform debate. Until 1992, Levy worked for Health One Corporation in Minnesota, where she held positions of increasing responsibility, including vice president of strategic development and director of hospital planning. Before that, she was director of services for the aged and director of planning for Mercy Health Services in Michigan. Levy holds a master's degree in hospital and health services administration from Saint Louis University.

ENDNOTES

1. National Conference of State Legislatures, *State Fiscal Outlook for 2001: February Update*, posted February 28, 2001, updated March 8, 2001; accessed March 30, 2001, at http://www.ncsl.org/programs/fiscal/sfo2001.htm. These states were Arizona, Colorado, Connecticut, Delaware, Florida, Georgia, Idaho, Illinois, Indiana, Kentucky, Maine, Maryland, Massachusetts, Missouri, Montana, New Mexico, North Carolina, Ohio, Oklahoma, Texas, Vermont, Virginia, and Washington.

2. Charles N. Kahn III and Ronald F. Pollack, "Building a Consensus for Expanding Health Coverage," *Health Affairs*, January/February 2001, 40.